SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Otezla® (apremilast)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

DIAGNOSIS	Recommended Dose
Active Psoriatic Arthritis (PsA)	• Titrate to recommended dose of 30 mg twice daily. 60 tablets every 30 days
Moderate to Severe Chronic Plaque Psoriasis - who are candidates for systemic therapy or phototherapy	• Titrate to recommended dose of 30 mg twice daily for adults. 60 tablets every 30 days • Titrate to recommended dose of 20 mg orally twice daily for peds pts weighing between 20 kg to < 50 kg, and 30 mg orally twice daily for peds pts weighing ≥ 50 kg. 60 tablets every 30 days
Oral Ulcers associated with Behcet's Disease	• Titrate to recommended dose of 30 mg twice daily. 60 tablets every 30 days

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CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

DIAGNOSES: Check the applicable diagnosis below or authorization will be denied.

❑ Active Psoriatic Arthritis (PsA)

- ❑ Member is 6 years of age or older
- ❑ Trial and failure of **TWO (2)** preferred drugs below:

❑ adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima® (adalimumab-bwwd)	❑ Enbrel®	❑ Pyzchiva® syringe/vial (Requires trial and failure of a preferred TNF-alpha inhibitor)

❑ Moderate to Severe Chronic Plaque Psoriasis - who are candidates for systemic therapy or phototherapy

- ❑ Member must meet **ONE** of the following age and diagnosis requirements:
  - ❑ Member is 18 years of age or older with plaque psoriasis
  - ❑ Member is 6 years or age or older and weighs at least 20kg with moderate to severe plaque psoriasis
- ❑ Must have a previous failure on a topical psoriasis agent and be a candidate for phototherapy or systemic therapy
- ❑ Trial and failure of **TWO (2)** preferred drugs below:

❑ adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima® (adalimumab-bwwd)	❑ Enbrel®	❑ Pyzchiva® syringe/vial (Requires trial and failure of a preferred TNF-alpha inhibitor)

❑ Oral Ulcers associated with Behcet's Disease

- ❑ Member is 18 years of age or older
- ❑ Member must have ulcers associated with Behcet's Disease

Medication being provided by Specialty Pharmacy - PropriumRx

Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

REVISED/UPDATED/REFORMATTED: ~~10/31/2018; 11/18/2018; 12/9/2018; (Rev) 4/6/2019; 11/23/2020; 7/19/2021; 1/5/2022; 1/12/2022; 7/8/2022; 6/26/2023; 11/9/2023, 8/27/2024, 10/17/2025,~~ **12/14/2025**